Effective interaction in school health can be fruitfully developed on the basis of a school survey. How this may be accomplished is presented and discussed in the following report.

EFFECTIVE INTERACTION FOR SCHOOL HEALTH

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EFFECTIVE interaction for school health, according to one little eight-year-old girl, is when her four brothers intervene when she is getting the worst of a fight on the school grounds. It is important to know who received protection from accidental injury, and who reacted with whom for the positive results.

Another phase of the dynamics of interaction is demonstrated in the story of a county health officer, in a western Kansas county, who became concerned when the local school boards would not comply with his recommendation to replace their outmoded and ineffective fire extinguishers. His statutory responsibility as county health officer to conduct school evaluations did not impress them. Following several attempts to educate and persuade, he finally stopped by each school in his car, picked up each fire extinguisher, and returned to his office. There, he notified the schools that they would be closed within 24 hours for operating without appropriate fire protection equipment. Previous board arguments about "expense," "we'll look into it," and so forth, evaporated and the necessary changes were made. A school health action committee was also formed in the county, its unvoiced objective—to keep that "darned-fool health officer from acting up again." As can be guessed, this led to the initiation of communication and understanding between all parties, and marked the beginning of a productive county school health committee.

To have effective planning and understanding of a health program for children of school age, action must take place between groups around a vital issue. Coordination and cooperation must be more than words for this to take place. Preschool experiences and facilities, community, cultural, and social patterns must also be part of this interaction.

Informal Survey

In an attempt to obtain a broad picture of school health responsibilities, a survey questionnaire was sent in November, 1964, to the 50 state health departments and the District of Columbia. The survey was conducted purely as a convenient means of providing an index on other states' activities, for use in the Kansas program. The tables are a compilation of the questionnaire answers and are not presented as in depth, statistical data.

The questionnaire was enclosed in a friendly letter sent to state health officers and/or school health program directors in the 50 states and the District of Columbia. The findings are reviewed and a special element of the survey is discussed. A few conclusions are drawn from the study and from experiences in

Table 1—School health program responsibility (results of a survey of state health departments)*

Responsibility of State Health Departments (Statutory or otherwise assigned.)	46
Sections of health departments involved in programs:†	
Maternal and child health	35
Health education	16
Special school health section	8
No particular designation	1
Other	13
Responsibility of State Departments of Education (Statutory or otherwise assigned.)	3
Cooperative Responsibility with Other Agencies:	
Department of education	39
Department of social welfare	3
Prviate agencies	7
School health council	10
Other	8

* Sent to 50 states and the District of Columbia. Replies: 49, or 97 per cent.
† Several health departments listed more than one section working in school health.

Kansas which demonstrate effectiveness, or lack of it, in interaction in school health programs.

Information obtained demonstrates that there are many jurisdictional variations, different legal and statutory definitions and degrees of interest of many disciplines in the area of school health (Tables 1 and 2).

Forty-nine replies were received to the 51 questionnaires sent.

Comment on Table 1

Three state health departments reported no responsibility for school health programs and indicated that state departments of education were solely responsible.

Forty-six health departments described a major legal or practical responsibility for school health, but this does not show the depth or organization of this responsibility.

Thirty-nine departments of education are also listed as having joint and/or other legal assignments for school health. Not shown is their official association with health department responsibility.

Eight interdepartmental committees of health and education on school health were reported, as well as ten state school health advisory councils, and seven showing varying patterns of joint responsibility with voluntary health agencies, governmental agencies, and professional organizations. What these figures do not show is the character and effectiveness of these committees.

Where health departments stated a responsibility for health programs for school age children, they were asked to indicate which divisions of the health department conducted the program. The names of the Division of Maternal and Child Health and Health Education appeared most frequently. The figures show that in many cases more than

Table 2—School health program responsibility*

Health Department Activities in School Health	
Environmental inspections and standards for school buildings	39
Development of health education materials	27
Training teachers in health	27
Specific health services:	
1. physical examinations	32
2. immunizations	39
3. vision screening	37
4. athletic examinations	28
5. dental services	36
6. hearing screening	39
7. other	15
Direct involvement in planning health curriculum in schools	19
Development of and involvement in mental health planning in schools	22

* Out of 49 responses to the survey, approximately 37 or 78 per cent prepared unsolicited comments, or sent copies of laws and policies, or program books and materials on school health.

one division was involved. What is not shown is the manner in which these assignments are assumed or how they are implemented.

Comment on Table 2

Activities of state health departments followed expected patterns, showing:

hearing screening	39
vision screening	37
physical examinations	32
immunizations	39
opportunities and responsibilities to work in health curriculum development	19
leadership in school mental health programs	22
responsibility for health training of teachers	27
evaluation or setting standards for school environment	39

Surprising Element of the Survey

The figures in Tables 1 and 2 indicate much activity or responsibility for activity in school health. It was the descriptive, unsolicited comments of 75 per cent of the respondees which was the most surprising element of the survey. Some of the dynamics of involvement were apparent in these responses and were reflected in the appended narratives, state plans, laws, policies, and materials sent in.

The comments cannot be recorded individually, but an attempt has been made to group them into the areas of concern most frequently mentioned—legislation, interdisciplinary committee activity, school construction patterns, training and personnel shortages, health education, and an underlying recurrent questioning of the relationships of school health programs to the cultural and subcultural needs of the community.

State Legislation and School Health—Several state health department directors remarked on obsolete and outmoded school health legislation which has remained on the books and which they are presently trying to continue to implement. Solutions were not offered. Ten of the examples cited, for instance, concerned the requirements that children receive annual physical examinations at school. "This is a costly program which uses much staff time. Physical examinations given at the school vary from $2.50 to $3.50 per child, and we are not sure the benefits are measurable." (Quotation from survey.) Lack of legislation in certain areas of health, as supporting measures, was also quoted as equally frustrating. The value and effectiveness of follow-up programs to these services are not always accurately determined.

Health Councils and Interdisciplinary Committees—These were mentioned by all (37) of the commentators. Some directors expressed total frustration at attempts to initiate such committees and usually blamed the uncooperativeness of all other groups, or they stated that they were not attemping such interdisciplinary work because it complicated their own work. Several successful council activities were described, as well as the morbid details of four unsuccessful ones. According to the narrators, the effectiveness of these groups was dependent on their degree of involvement and interrelationships with the scope of cultural and social factors in the community. Where the councils remained "school isolated," they appeared to fail.

School Construction—In this area, the following comment keynotes the group concerns: "Our review of architectural plans—in the preplanning period—is one of the most gratifying and valuable activities of our department." (Quotation from survey comments.)

In our changing technology, probably the field of architecture is changing most rapidly. New materials and new concepts of construction are providing imaginative departures from the traditional rectilinear school building which is divided into more rectilinear spaces which are further subdivided into

smaller rectangles into which children are arranged like ice cubes in a tray.* If we add to this a formulized number of sanitary facilities, inconveniently located, inadequate parking facilities, and last minute lunchroom planning, we have a picture of many existing buildings. To achieve the best application of these new materials and architectural concepts means to develop the definition of a "healthful school environment" in its broadest sense—to enhance student performance and to contribute to his emotional, social, and physical growth. How can this occur if variation in school planning is so uneven and so varied?

Although 39 states reported evaluation and inspection of school environments as a responsibility of the health department, they indicated that other agencies, such as the fire marshal's office, the highway department, the state architect's office and the school facilities section of the department of education, may also be involved. It was also obvious from the comments that these were not always in complete harmony or informed of each other's activities. Traffic, playground, stairway, and other structural hazards are noted and corrective action is requested in these programs. Alteration of school buildings may often result from such analyses, but more often changes are brought about with difficulty. In new school construction there is wide variation in plan approval. Some states require no review or approval of schools except to meet basic building codes and regulations. These basic codes do not include an evaluation of the functional and educational design of the building, the quality of the light, or the psychological or physiological impact of color, noise, or thermal comfort. Such preplanning requires the best talents of an architect, teacher, administrator, engineer, sanitarian, custodian, counselor, dietitian, nurse, physician, parent, and specialist in child growth and development. A town council or city planning member may often participate. New concepts in school design are implemented through such interaction. Buildings emerge which literally "stay out of the way" of school activities, supplying maximum floor space and designed spaces to suit changing teaching-learning technics.

The disciplines mentioned in the preplanning for school construction represent the full spectrum of health specialists needed for an effective school health program—and that leads to the next area covered in the comments.

Shortage of Personnel—Each response indicated concern with finding the appropriate person to fill positions in on-going school health programs. The problem was not always described as a financial one but, instead, a lack of availability of these trained workers.

Health Education—Health education, including health instruction, health training for teachers, and development of a health curriculum, appears from the comments to be the area of most neglect—or most controversy in the school health program. The issue is complicated by basic concerns over teacher education in health, health unit requirements by schools, and health instruction content and methods. Meanwhile, biased commercialized and highly subsidized "health education" takes place daily through the mass media. Similar subsidy to counteract this influence was not suggested in the survey comments. The significant element in the comments was the nearly 100 per cent reference to the need for implementing and evaluating health education studies now in progress and to develop approaches in keeping with this age of "instant knowledge."

The survey data raise many ques-

* From a discussion with John Shaver, A.I.A., at the Kansas University Medical Center, postgraduate course on school health, "The Environment of Learning."

tions which were not answered, such as: "What would a similar survey of departments of education show?" A survey of this type has just been conducted, but the results are not tabulated. They may reveal a completely different understanding of school health program responsibility or they may show an opposite grouping of data. Whatever is shown may not be too important, if there is adequate communication between those groups who think they have a responsibility. As the comments of the survey were grouped and studied, many facets of the school health program emerged more sharply and suggest that there are meaningful experiences around which effective interaction may be established.

Summary of Concerns for Action

Examination of presently existing *state and local school health legislation* and how it is being implemented could be the focal point for interagency cooperation to up-date, revise, repeal, or initiate legal responsibility. Consideration of federal legislation affecting school health is a natural next point of interagency and interdisciplinary exchange.

Reevaluation of *school health council activities,* or other interdepartmental committee work, should take place to find out if these groups are as effective as they are "on paper."

Are needed programs in operation? How much personal contact by members with personnel from all community health agencies is there? Is an active instrument being provided so that individuals can meet and hopefully collide —head on? This is the kind of situation which stimulates productive disentanglement and reassessment of ideas.

Renewed attention to the meaning of the *school environment* is imperative. Active involvement of the American Institute of Architects state chapters, in whatever cross-fertilization committees are in effect, is important. In fact, involving the state A.I.A. chapters is a project in itself. The architects have already demonstrated their ability and interest in leadership roles in designing preschool facilities for disadvantaged children.

In the matter of school health *personnel shortages*—a serious proposal is made to inventory the health specialists in the community—those who are active or inactive, and explore technics for broadening "whose responsibility is whose," since it makes very little difference, if there is no "who" at all to assume responsibilities. An incisive review of the allied health professions should enable those responsible for school health programs to assign "less than traditional" areas of responsibility to various staff members. Recruitment should be aimed at finding and training specific personnel and offering incentives to keep them on the job. With the growing number of school children, there are fewer and fewer adults with whom they may interact, giving emphasis to the need for professional persons to be utilized to the utmost with as little waste of talent as possible. For example, sex education is often assigned to traditional health personnel. A thoughtful Catholic priest whose parishioners frequently request that he obtain a physician for them for a talk on "sex," says that he usually counters with his own question to them: "Who's sick?"

Local Interaction Example

One specific example of effective interaction is outlined in an action assignment of the Kansas State School Health Advisory Council, and covers all emphasis areas in the comments as outlined. One of the many requests to the council was in the area of high school athletics and physical activities in school. In cooperation with the Kansas High

School Activities Association, a more definitive physical examination for participation in any activity program was designed. School districts were asked to evaluate the practices used in examining athletes. Physician-student-parent conferences were encouraged to assure an adequate history, which would build on previous family physician examinations or other routine examinations. Physicians were impressed that the emphasis was not on "ruling out" participation for any child but rather for "ruling in" as many as possible through correction of disability and modified programs. Local medical societies were approached to sit in with health and physical education activity directors.

This has resulted in a number of school districts developing a policy which lengthens the time period prior to initial practice in which physical examinations may be obtained. Families and students are urged to have this examination from their own physician in his office. For boys and girls who have not been examined before the school term, local physicians have arranged blocks of time in their offices or during evening hours in which these families and the children may be examined at minimal fee. This has been a tedious process, less smooth than mass examination at school. However, those who have participated believe it is worth the special arrangements, the provision of transportation for parents and children, and the scheduling of odd hours. For some families, this method has encouraged the first thorough examination of children since elementary years.

The preventive aspects of an athletic program are more evident to parents, students, coaches, and physicians, due to the improved communication. Special efforts have been made to visit the "hard to reach" families whose children derive much benefit from athletic and physical education programs. If this fails, the boys and girls are examined as well as possible without parent information, and ample opportunity is provided for "talk" between the physician and these students. A guide for coaches, physicians, and administrators was developed to further the philosophy of prevention and control of injury, and included a description of the physical examination procedure. Four annual state coach-physician conferences have been conducted as follow-up and continuing education in this area.

The implications and directions of the survey for effective interaction in school health can be summed up in the wise quotation of a contemporary philosopher, Pogo: "We has met the enemy—and they is us."

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